UNHCR for new refugees. The tighter controls across borders will make training etc in Pakistan more difficult to organize than formerly.

Restrictions upon female employment are occasionally tightened and not uniform across the country, depending on who the currently reigning person is and which people comprise the department of vice and virtue locally. The health sector is fortunate, in that, women work in this sector with relative freedom but have to operate within the mores imposed by the authorities.

IbnSina

IbnSina operates health facilities in 4 Regions (West-Central, South-East, South-West and Central), 12 provinces (Nangarhar, Parwan, Wardak, Paktia, Bamyan, Baghlan, Ghore, Ghazni, Paktika, Kandahar, Helmand and Zabul) and provides EPI services in 33 districts. There is also a liaison office in Kabul. This office has additional responsibility for the supervision, support and monitoring of 3 clinics in Hazarajat and the clinic in Kot e Ashroo.

The organization runs a total of 33 facilities, of which 23 are MCH clinics (M1 clinics). 2 of the facilities are Maternity homes or Emergency Obstetric Centers (EOC). The one in Ghazni is a comprehensive EOC since the ICRC operates a surgical facility that is able to perform Caesarian sections as needed. The EOC in Gardez has no facilities for Caesarian section. Surgical facilities are available in Kabul (2 hour's drive) or Baraki Barak (one and a half hour's drive). The other facilities are C1 and C2 clinics.

The total staff roll is about 480 with 30% of these being women. The staffing pattern for the different facilities has been standardized. Some of the positions remain unfilled because of the difficulty of finding trained staff or deploying female staff in an essentially male staffed clinic. In some areas, male vaccinators have been recruited for the fixed centers instead of female vaccinators who had been proposed.

The organization has its Main Office in Peshawar and 4 Regional Offices. An additional office in Kabul serves as the liaison office with the authorities. This also supports 4 clinics. The Kabul office is also an important link in the chain of communications between the Main Office and the Ghazni and Bamyan Regional offices.

The Main Office is responsible for donor liaison and reporting, policy and strategy formulation, human resource development, financial management, logistical support and supervision and monitoring. It has a Directorate, a Technical Section, an Operations section and a Finance section. The Regional offices have direct implementation responsibilities. A full regional office should have:

- a Director
- a male PHC supervisor
- a female PHC supervisor
- a cashier

- an administrator
- a radio operator
- support staff.

The offices in Kandahar and Bamyan do not have female supervisors. The office in Nangarhar has a TBA supervisor in addition to the other staff. The office in Ghazni has further additional staff: a Laboratory Supervisor, a Health Education Supervisor and 2 Community Based Health Care Supervisors. The Kabul office has a Director and an administrator/cashier.

New Program Developments

Since 1998, the new developments in its program have been:
- Strengthening of its EPI services with an improved output
- Partnership with UNFPA to strengthen its Reproductive Health Services
- Training of the majority of its doctors and Mid Level Health Workers in Reproductive Health
- Training of the community based health program staff of 9 Community Health Supervisors and 53 Village Health Volunteers in Reproductive Health
- Training of the Main Office staff in the supervision and management of Reproductive Health programs
- Recruitment and training of about 40 TBAs in the catchment area of 4 of its clinics in the Nangarhar region
- A recent expansion to the refugee community in Pakistan. i.e. support to the Al Jihad hospital in Jalozai and ambulance services for the New Jalozai camp
- The opening of an EOC in Gardez
- A goitre survey in Kouz Konar district
- An anemia survey in all regions
- An EPI coverage survey
- Initiation of a pilot project for community based growth monitoring
- Participation in the national HIS task force with a new national OPD reporting system.
- The HIS system has been redesigned in the Access software, making it more user friendly and flexible.

INTERNAL EVALUATION

The objectives of the evaluation were:

4. To assess how far the recommendations of the previous evaluation have been implemented and how this has affected the organization.
5. To assess the quality of care at clinic level
6. To assess the capacity at Regional level to maintain and improve quality of care in the facilities.*(Annex 1: TOR Internal Evaluation)*

In addition to the above objectives, it was felt that the evaluation should also be a learning experience for the organization. Therefore, the evaluation was mainly conducted by the Regional team after a day's discussion and training.

METHODOLOGY

Evaluation Design

An evaluation needs to be undertaken either against some standards or with another organization or within an organization, over a period of time or against client/patient satisfaction.

Objective 1
The assessment of the implementation of the recommendations from the Mid Term Evaluation was a relatively straight forward task. All the required information was available in the previous project reports.

Objective2
The assessment of the quality of care at clinic level needed some careful designing. Since no such previous evaluation has been undertaken in IbnSina and it is difficult to evaluate against another organization unless similar methodologies are used, a set of tools were designed, using a scoring system. These were formulated upon the following:

- A set of quality of care forms utilized by the International Medical Corps
- A set of tools used in a recent external evaluation of the Swedish committee's health care program
- The background papers used by the SCA evaluator that correlates certain factors with patient utilization. Patient utilization rates wre considered the hall mark of a good clinic.
- A set of criteria suggested in 'Primary Child Care' by King, King et Martodipoero for use by health care workers for the evaluation of the quality of their own clinics

The main factors that have been used to formulate the tools for the evaluation were:

- The structure of the clinic and the access to privacy of the client
- Facilities for patients such as suitable waiting areas, latrines, safe water

- Good waste disposal and disinfection practices
- Access to care by trained staff on regular and reliable basis
- A regular, constant and reliable supply of drugs and other medical supplies
- The presence of equipment necessary for good clinical care
- Good cold chain and supply for the EPI
- Knowledge of the various cadres of workers based on the common problems and the training given by the organization
- The attitude of workers based on what was judged as vital information to be given to patients if their right to knowledge of their condition and treatment were respected.
- Practice of workers based on their job descriptions and training given by the organization

A set of forms were designed to collect the necessary information. Questions regarding knowledge, attitude and practice for the EPI sections were drawn up in conjunction with the supervisory staff. Checklists for necessary drugs and equipment were based on those provided by the organization and those considered vital for good paediatric and maternal care (List from'Primary Child Care' plus a constant supply of drugs needed for maternal care, including contraceptives). IbnSina does not treat tuberculosis in its clinics, though these are listed as essential drugs for paediatric care. The newer policies such as DOTS etc. makes the treatment of TB a more specialist area and IbnSina does not undertake it. Therefore, anti TB drugs were not included in the list.

<u>Objective3</u>
The assessment of the capacity of the Regional staff to support the clinics was not done formally. This was done informally during the evaluation process.

Implementation

The forms were designed at the Main Office in consultation with Main Office staff. The list of drugs and equipment were also compiled similarly. A form for assessment of laboratory quality was not designed as this was outside the competency of the consultant.

<u>Areas Evaluated</u>
Two regions were chosen purposivley for the evaluation namely, Nangarhar and Ghazni. Both these regions have only MCH clinics and also have female supervisors. In addition, Ghazni also has two EOCs.

In the Nangarhar region, 4 clinics were chosen randomly. In the Ghazni region, both EOCs and five of the six clinics were visited. Kakrak was not visited as the 2 doctors were newly appointed and the Regional team felt that the evaluation would not reflect their efforts fairly.

<u>Evaluation Teams</u>
In each region, the first day was spent with the Regional teams in order to discuss the forms and as a training exercise in the evaluation. The day's training and discussion gave the Regional team an opportunity to feed into the form design.

In Nangarhar, the team comprised the Regional Director, the male and female supervisors and the TBA trainer and supervisor who is also a trained nurse trainer and has recently conducted a formal training for nurses in the region.

In the Ghazni region, the team comprised the Regional Director, the male and female supervisors and also the EPI Officer from the Main Office who was there for routine supervision. The Laboratory Supervisor joined the team for part of the evaluation.

<u>Review of Forms</u>
The list of necessary drugs was revised at regional level. Aldomet, doxacycline, novaject and ferrous sulphate solution that have been judged as necessary by the organization were not as yet part of the list supplied to the clinics though they will be included in the new supplies. These were deleted from the list.

The form for the assessment of the knowledge of the Health Educators was also revised as the team felt that they would not know the following:

- Breast feeding will help placental detachment
- Breast feeding will help uterine shrinkage
- The numbers of glasses of ORS needed to be given to prevent dehydration according to age

The form for the assessment of nurses requires them to know that instruments need to be submerged in chlorine solution for 20 minutes for High Level Disinfection. The nurses had been taught to immerse them for 10 minutes in accordance with notes handed out for decontamination, during the training given in the Reproductive Health courses. 10 minutes was accepted as a correct answer though the regions were asked to revise the instructions.

Each clinic was visited by the whole team. A meeting was held with all the clinic staff and the purpose of the visit explained to them. Each team member was assigned two to three forms to be used for different staff of the clinic. After the evaluation which was done while the staff carried out their normal duties, a meeting was held with the clinic staff to give them feed back.

Biases

- The regional staff has a stake in the quality of the clinics. The assessment done by them may have been subjected to some bias because of this.
- Some clinics had prior information of the evaluation and a bias may have been introduced in clinic cleanliness etc.
- The team arrived earlier than the clinic staff (the team was early) and there was some resultant confusion viz. the antiseptic solution for the thermometer and tongue depressor was not made up as the nurse became flustered by the teams arrival

- In Qasaba, the Health committee had seized the opportunity provided by the visit to lobby for continuation of the clinic site and this interfered with the process of the evaluation.
- The team arrived late at Khwaja Umari clinic because we had decided to assess 2 clinics in the same day. As a result, attitude and practice could not be fully assessed
- Often, there were more than 1 vaccinator at the clinic and the answers were given collectively

RESULTS AND DISCUSSION

I. OBJECTIVE 1

The Mid Term Evaluation was carried out in a participatory manner, using both field visits and a SWOT workshop. Several recommendations were made covering program activities, the different policy aspects of the program, the organization and future policies.

The reports submitted to donors since 1998 were reviewed. The recommendations of the Mid Term Evaluation were also reviewed.

Information not available in the reports was obtained from the appropriate departments.

A. Recommendations Implemented

(The recommendations are attached as Annex 2)

Most of the recommendations have been implemented. This has strengthened IbnSina's capacity and improved the quality of care in its health facilities.

The fact that it did not substantially expand its program (as recommended) has given it time to consolidate its work and strengthen management. Expansion now would be entirely possible, provided that funding and qualified staff are available.

Most of the recommendations that have not been implemented have been those that are not within IbnSina's control. Many of these have to do with UNICEF contracts and data. Memisa, now Cordaid had proposed that a consultant will come later in the year to undertake the consultancy for management strengthening.

1. The PHC Trainers/Supervisors have been included in training for health education and are involved in the supervision of health educators. However, the male Supervisors have not been included in TOT courses. There has also been some change and new staff are in some positions.
2. Since 1998, 28 latrines and 9 wells have been constructed/rehabilitated.
3. Organizational commitment has been developed to a large extent to the use of good sanitation and safe water in its offices and facilities.
4. Other organizations have been involved in the construction of wells and latrines but on an ad hoc basis.
5. Female health educators have not been recruited for the C1/C2 clinics. These are located in Kandahar and Bamyan and it is difficult to deploy female staff in all male clinics.
6. Training in Growth Monitoring has been conducted in some regions. The use of Afghan calendar months in growth charts is still not universal.
7. A pilot project for community based growth monitoring has been initiated in Nangarhar.

8. The purposes for which Growth Monitoring are used by the organization have been understood at organizational level.
9. Successful negotiations have been held with UNICEF to provide motorcycles for supervisors and bicycles for vaccinators and transportation cost for outreach costs.
10. UNICEF has agreed to fund Mobile work in some areas but they will not agree to all areas where IbnSina feel it necessary. IbnSina uses funds from its cost recovery for this purpose.
11. IbnSina has rationalized its EPI work. It implements it only in areas where it also has clinics providing integrated care. However, it continues the program in Paktika as no other organization is currently able to take it over.
12. EPI coverage is now reported to reflect the districts in which IbnSina is working and not the entire province. IbnSina has been able to raise its coverage significantly in the Ghazni and Paktika areas and minimally in the other areas.
13. Coverage and cost efficiency and effectiveness analyses have been done. These reports have been used to lobby for the use of more effective strategies.
14. The number of EPI teams in Paktika have been increased.
15. Female vaccinators are employed in most MCH clinics. In some, male vaccinators are used to provide fixed services as it is difficult to find suitable women. In Shiveh, there is no fixed center.
16. EPI training courses have been held for Regional staff but the Regional Directors were not included.
17. The Community Based Health Care Program was evaluated as planned.
18. An attempt has been made to include the staff in considerations of coverage for EPI and curative care but this does not include all clinic staff.
19. Health educator, receptionist and nurse positions have been standardized for all MCH clinics. Staffing levels have otherwise remained at the same levels, as was recommended.
20. Some attempts have been made to improve patient waiting areas but this is not as yet sufficient. Patient flow remains somewhat problematic.
21. Better microscopes have been purchased and are in use.
22. Female doctors are trained in general medical issues and PHC issues.
23. The Maternity Homes or EOCs operate over 24 hours.
24. TBA training has been undertaken in Nangarhar and about 40 TBAs have been trained to date.
25. The range of contraceptives has been reviewed. Reproductive Health training has been done on a large scale and apart from spermicides, diaphragms and permanent methods, all other contraceptives are available at the clinics with the aid and support of UNFPA.
26. A surveyor has been recruited. The His officer has had training in epidemiology at the Aga Khan University, Karachi.
27. IbnSina was part of the national HIS task force. A new system for analysis, using Access software, has been designed partly by the SCA and partly by IbnSina.
28. IbnSina is using the data collected but this can be widened.
29. IbnSina follows the guidelines for the opening of a new clinic in terms of community participation as defined at the workshop. It uses buildings donated by the 'community' or the MOPH.

30. The level of women in the program has risen from about 18% to about 30%. An Afghan woman has been recruited as the Reproductive Health Officer. The new data entry officer is also an Afghan woman. TBAs have been trained in Nangarhar. Training courses have been conducted in Peshawar.
31. Cooperation and coordination with other organizations continues as before. There has been a formal understanding of cooperation amongst the SCA, IbnSina and IMC.
32. All the recommendations for specific capacity building have been implemented.
33. Radios have been purchased and installed in the 4 regions. The Government of Pakistan has subsequently banned the use of radios in Pakistan by NGOs. It is therefore, not possible to communicate directly from Pakistan to Afghanistan on the radio.
34. Cost recovery has been increased to 40% of all drugs except contraceptives. The fees have also been increased for new cards, consultation, dressings and injections and deliveries.
35. An assistant pharmacist has been recruited to improve the supervision and monitoring of drugs.
36. Regional Directors and cashiers have training and orientation in financial procedures before assuming posts.
37. The financial manager from Memisa held a workshop for discussion of health related finacial analysis.
38. Funding sources have been widened by the addition of support from UNFPA.

B. Recommendations Not Implemented

1. Impact indicators have not been developed, again because of the difficulty of collecting baseline data.
2. A standard latrine design for the organization has not been developed.
3. UNICEF is still not able to sign contracts and release funds on time in spite of many negotiating forays.
4. It is difficult to find a donor who will fund a lot of the EPI work when the same donors fund UNICEF for the same work.
5. More accurate population figures for the target areas of EPI have not been obtained except in one district in Ghazni where DACAAR has done house to house surveys to collect the figures. The actual figure for this district is almost twice that given by UNICEF.
6. It has not been possible to recruit a person with necessary skills to manage the Community Based Health Program.
7. It has not been possible to construct suitable waiting areas for all clinics because a sufficient rehabilitation amount has not been budgeted.
8. A referral system for TB patients has not been specifically developed where possible.
9. Training input for planning and management from Memisa has as yet not taken place.
10. The board has not been able to play an active part in fund raising. It has not been able to develop inter-sectoral collaboration in a specific program design.

II. OBJECTIVE 2

(all forms attached as annexes)

A. Clinic Quality (Form 1)

Form1, used to assess this aspect, consisted of four sections:

- Clinic structural quality to assess access to privacy, facilities for patients and use of proper techniques for waste disposal and high level disinfection
- Staff attendance
- Stock of drugs and medical supplies
- Stock of essential equipment

A two step scoring system was used. Each section was scored for quality. A high quality was then given 5 points, intermediate quality was given 3 points and low quality was given 0 points. A cumulative score was then attained for all four sections and the quality of the clinic was judged on the basis of this total score.

Prior to the evaluation, the Regional teams were asked to predict the quality of each clinic.

Clinics in the Nangarhar Region

	Predicted	Actual	Remarks
Charbag	HQ	IQ	No aminophylline tabs
Shiveh	IQ	IQ	No aminophylline tabs
Bagrami	HQ	IQ	No aminophylline tabs, chloramphenicol eye drops, low stocks of cotrimoxazole and paracetamol suspension, no ringer lactate
Qasaba	HQ	IQ	No ampicillin, cotrimoxazole and paracetamol suspensions

Note 1: HQ= High quality, IQ = Intermediate Quality, LQ = Low Quality
Note 2: No chlorine solution was used to decontaminate syringes as this had not been part of the instructions to the clinics

Aminophylline tablets had been transferred to the Main Office two months prior to the evaluation. The Nangarhar Regional Office had requested the MO to re-supply them with this item but this had not occurred. This shortage had been pointed out by the RO before the evaluation exercise.

The suspensions had not been requested from the Regional Office since these are not part of the extra kits and the clinic heads felt that it was pointless to request extra. The shortages of suspensions had not been forecast prior to the evaluation.

The list of essential drugs and medical supplies had a column for quantity as well. The MO Pharmacist estimated this quantity as the amount required for 2 weeks. A 2 week

INTERNAL EVALUATION OF IBNSINA'S PRIMARY HEALTH CARE PROGRAM

APRIL 2001 TO JUNE 2002

Dr.Panna Erasmus. M.B. B.S. , M.Sc.

period was used as the minimum stock that should be present at any time, on the assumption that 2 weeks was the turn around time for re-supply. This will of course vary with the regions and the distances between the Regional Offices and the clinics.

An analysis of the use of these suspensions and the most common conditions for which are used was done using the monthly report forms at the RO.

Number of Children<5years by Diagnosis and Suspensions Used in April 2001

	No. of children <5 years	No. of Cases of Bloody diarrhoea	No. of ARI and ENT	No. of ARI, Pneumonia	Total Cases	No. of Ampicilin Suspension Used	No. Of Cotrimoxazole Used	Total Bottles Used
Charbag	371	28	28	1	**57**	24	39	**63**
Shiveh	277	36	22	10	**68**	22	79	**101**
Bagrami	542	122	45	101	**268**	43	66	**109**
Qasaba	547	41	111	47	**199**	58	107	**165**

Of course, the suspensions are prescribed for reasons other than those analysed and not all cases of bloody diarrhoea are treated as bacillary dysentery. However, the numbers are roughly similar and it would seem that there is no obvious misuse. The incidence of a large number of cases of bloody diarrhoea in Bagrami as compared to the other clinics in the same season should be looked into.

Clinics in the Ghazni Region

	Predicted	Actual	Remarks
Ghazni Markaz	HQ	IQ	Ampicillin caps, Erythromycin tabs, iron tabs, paracetamol tabs penicillin procaine, condoms short
Khwaja Umari	HQ	IQ	Condoms, oral pills, ORS, paracetamol tabs short
Gardez	IQ	IQ	Ampicillin caps, chloramphenicol eye drops, oral pills, erythromycin, iron tabs, folic acid, metronidazole tabs, paracetamol tabs and suspension and penicillin procaine, ringer lactate and 10 ml syringes short
Qarabag	HQ	IQ	Aminophylline tabs and amps, gentian violet, ORS, paracetamol tabs and susp., sterile gloves and 10 ml syringes short
Muqour	HQ	IQ	Aminophylline tabs, chloroquine tabs, oral pills, mebendazole tabs, ringer lactate short

Note 1: HQ= High quality, IQ = Intermediate Quality, LQ = Low Quality
Note 2: No chlorine solution was used to decontaminate syringes as this had not been part of the instructions to the clinics

The shortages of drugs exist for a wider range of drugs and supplies. 3 clinics were short of 1 or 2 contraceptives. 2 clinics were short of iron tablets.

The Regional Office stated that they had no supplies in their stock to re-supply the clinics. This period was in fact a critical period in that the last supply from the Main Office had been done in the June of 2000 by the Main Office and the new supply had as yet not come in.

Drug stocks are part of the monthly reports. This raises the following questions:

- Is the information collected each month analyzed regularly in a manner that is easy to see and understand?
- Is this analysis carried out by the Regional Office along with the clinic staff on a regular basis?
- Is there a data base that is usable by the Main Office staff easily? This would allow more Main Office support for re-distribution between regions and clinics to be given.
- Should there an over lap time of at least a month between the last supply and the new supply from the MO?
- Should there be an addition of paediatric dosages in the extra kits?
- Should there be a flexible policy to allow for some procurement in Afghanistan?

Some of these questions have already been answered:

- The Nangarhar region carries out monthly meetings for a day each with all the clinic heads. The Kandahar office has a quarterly meeting. The Ghazni office has been asked to hold 2 monthly meetings with clinic heads after the evaluation visit. The other 2 regions do not carry out this procedure. A decision to carry out such meetings had been made about 8 months prior to the evaluation. The lack of uniformity with which this is being done is indicative of both lack of follow up on the part of the Regional staff and the Main Office. Part of the problem is also that the minutes of the meeting were not drawn up and circulated.
- There is no data base at the Main Office which can be viewed easily. This should be developed in Access software as is the rest of the HIS.
- Yes, there should an overlap of at least one month between 2 supplies. The procurement and transport procedure seems to take at least 3 months and some time passes on the quality checks in Kabul.
- The possibility of some drug procurement in Afghanistan should be investigated
- Paediatric dosages should be included in the extra kits and suspensions should be reserved for under ones

In addition to this a question has been raise by the Regional Directors:

- Currently, the clinics divide the drugs supplied for a quarter into 3 parts. Should this 1 month quota be used up, the doctors are informed of this and asked not to prescribe the relevant drugs from the clinic pharmacy. If alternatives are available e.g. other

antibiotics, these are used; otherwise drugs are prescribed from out side. This raises difficulties in the monitoring of correct prescription practice and some possible complaints from patients who see drugs in the pharmacy and are asked to buy from outside. Should this practice continue or should sufficient drugs be supplied with the required supervision of prescription practice etc.?

The answer to this is not simple but a policy decision needs to be thought about and made. IbnSina is currently in the middle of a Green book analysis which will show whether the drug shortages are due to over prescription or due to insufficient supply.

For the sake of comparison with the Nangarhar region, an analysis of the numbers of under fives seen and suspensions used was done:

Number of Children<5years by Diagnosis and Suspensions Used in April 2001

	No. of children <5 years	No. of Cases of Bloody diarrhoea	No. of ARI and ENT	No. of ARI, Pneumonia	Total Cases	No. of Ampicilin Suspension Used	No. Of Cotrimoxazole Used	Total Bottles Used
Ghazni Markaz	245	10	82	16	**108**	43	42	**85**
Khwaja Umari	231	19	60	14	**93**	11	32	**43**
Gardez	60	5	2	2	**9**	0	0	**0**
Qarabag	134	5	48	22	**75**	38	87	**125**
Muqour	286	23	15	25	**63**	41	57	**98**

In Shiveh and Qarabag, significantly more bottles of suspension are prescribed than the numbers of cases analyzed. The only other reasons for the use of these antbiotics are urinary tract infections, abcesses and skin infections. The Region needs to have a discussion with the respective doctors in particular and all doctors in general during the monthly or quarterly meetings.

The shortages of paediatric suspensions was discussed with other Regional Directors who raised the following points:

- There are no paediatric drugs in the extra kits
- There is about 1 bottle of suspension supplied per day and even if the use of these is restricted to children<1 year, the number of paediatric dosages supplied is not adequate
- Paediatric dosage tablets for these common ailments should be supplied so that these may be used for children <1year, especially paracetamol

On the whole the clinics would have rated as High Quality if the scoring standards for drugs and medical supplies had been less stringent and were in a range. This was the single reason for the scoring of all clinics as having an Intermediate Quality. The expectation was that every one of the items on the list would be present. This was a deliberate decision because IbnSina prides itself on its regular supply.

B. EPI Quality (Form 2)

. This comprised of 5 sections:

- Quality of cold chain
- Vaccine availability and quality
- Record Keeping and administration
- Knowledge, Attitude and Practice of vaccinators (3 sections)

The quality of the services were rated as low if the cold chain was of poor quality.

EPI Quality Score, Nangarhar

	Quality	Remarks
Charbag	High Quality	
Shiveh	Not Applicable	SCA provides services once a week. The vaccinator had not visited for 2 weeks and had not informed the clinic that he would not be there
Bagrami	High Quality	Vaccines come by vaccine carrier, so the quality of this part of the cold chain was assessed
Qasaba	High Quality	Vaccines come by vaccine carrier, so the quality of this part of the cold chain was assessed

EPI Quality Score, Ghazni

	Quality	Remarks
Ghazni Markaz	High Quality	Syringes for DPT, TT and measles out of stock but bought for the day
Khwaja Umari	Intermediate Quality	No syringes for DPT, TT, measles and no BCG
Gardez	High Quality	
Qarabag	Intermediate Quality	No syringes for DPT and TT, measles and no TT vaccine
Muqour	High Quality	No syringes, but people asked to buy from private pharmacy

The intermediate scores were obtained because of a shortage of one or more vaccines.

There have been no syringes for DPT and TT for the last 2 months. UNICEF, Kabul did not have any and there were none in Islamabad. (The Afghanistan program uses auto

destruct syringes.) The form did not include this item in the scoring system on the assumption that should there be sufficient vaccine, there would be the right number of syringes supplied. There was no vaccine at the REMT or Kabul or Islamabad.

The EPI Officer from the Main Office had just returned from Paktika and asked for the transfer of 3000 syringes from there to the Ghazni region. However, it should have been entirely possible for IbnSina to procure 5 cc syringes for use. The Muquor clinic showed initiative in asking people to buy syringes. Unfortunately, this move was probably motivated by a possibility of profit, as the private pharmacy is owned partly by the Lab. Technician.

The lack of syringes has meant that only the fixed centers had been operating and the outreach and mobile programs had come to a stand still, which will, no doubt, affect the coverage and drop out rates.

Knowledge, Attitude and Practice of Vaccinators

	Knowledge			Attitude			Practice		
	HQ	**IQ**	**LQ**	**HQ**	**IQ**	**LQ**	**HQ**	**IQ**	**LQ**
Nangarhar	3			3			3		
Ghazni	5			4			4		

- *Total number of centers in Nangarhar = 3*
- *Total number of centers in Ghazni = 5 (Attitude and Practice could not be assessed in Khwaja Umari as there were no patients as team was late)*
- *Vaccinators in Nangarhar are MOPH staff but are under the direct supervision of IbnSina*

The gaps were:

Knowledge: some vaccinators did not know the following:
- The percentage of the community needed to stop transmission of disease
- All the steps needed to prevent neonatal tetanus, though they all knew that TT for the mother was part of it
- The definition of a fully immunized child

Attitude: many of the vaccinators did not inform the mother of the following
- The total number of doses/visits required to complete the course for the child or herself
- Possible side effects of vaccines and what to do about the fever

Practice: some of the problems seen were:
- Patient not positioned correctly
- Bottle and skin not cleaned with distilled/boiled water
- One team used dry cotton to clean the skin!!

The Maternity home in Gardez and Ghazni should make sure that those babies who are discharged during working hours should be vaccinated with BCG before discharge.

C. Knowledge, Attitude and Practice of Doctors (Form 3)

The questions for assessing knowledge were decided into 2 sections: general medical and obstetrics and gynaecology. The questions were about common problems viz: diarrhea. ARI, iron in pregnancy, causes of antepartum bleeding and post partum bleeding and pelvic inflammatory disease. All the doctors were asked all of the questions.

Currently, male doctors do not see female patients except for general medical problems but it has been part of their training. Male doctors can prescribe iron for women and diagnose and refer some problems without internal examination.

Since the questions were about basic problems encountered in the field and in issues in which training had been given, a high quality score was only obtained if all answers were correct.

Male Doctors, Nangarhar, total =4. Ghazni, total = 3

		Knowledge			Attitude			Practice		
		HQ	**IQ**	**LQ**	**HQ**	**IQ**	**LQ**	**HQ**	**IQ**	**LQ**
Nangarhar	*General medical*	3	1			4		4		
	Obs. and Gynae.		4							
Ghazni	*General medical*	3			2	1		3		
	Obs. and Gynae.		3							

Knowledge:

The male doctors scored lower in the obstetrics section than in the general medical section. This was expected. However, what was not expected was that many of them did not know the dosage of iron for propyhlaxis and treatment in pregnancy. The other gaps in knowledge were the treatment of PID and of course the causes of vaginal bleeding ante and post partum.

The one doctor in Nangarhar had a problem with the quantities of ORS to be given to a moderately dehydrated child.

Simple obstetric and gynaecology subjects should be included in the training conducted for male doctors. However, the 'Case Definitions' that are the guidelines for diagnosis nad prescription do not include these topics. Case definitions for these subjects should be drawn up.

Female Doctors, Nangarhar, total =4. Ghazni, total = 6

		Knowledge			Attitude			Practice		
		HQ	IQ	LQ	HQ	IQ	LQ	HQ	IQ	LQ
Nangarhar	*General medical*	2	2		3	1		3	1	
	Obs. and Gynae.	3	1							
Ghazni	*General medical*	6	1							
	Obs. and gynae.	6	1		6	1		6	1	

Knowledge:
It was heartening to see that most of the ladies scored well in both the general medical and the obstetric and gynaecology sections. However, the problems were the combination and duration of treatment for PID. One doctor did not know the dosage of iron used for the treatment of anaemia in pregnancy. Some doctors do not prescribe the required amount of drugs because of the instructions not to prescribe combinations of antibiotics. Again the lack of guidelines for the diagnosis and treatmetn of common obstetric and gynaecological conditions contribute to these gaps.

The problems in the general medical sections in Nangarhar were with questions regarding rehydration i.e. how much ORS should be given a moderately dehydrated child. In Ghazni, the use of the respiratory rate in the diagnosis of pneumonia was the problem.

There were no WHO charts for the treatment of dehydration in any of the rooms of the female doctors.

Attitude:
Both male and female doctors fared lower in the attitude section because they either did not tell the patient the diagnosis or when to come back or if it was necessary to return.

Practice:
The problem in the practice of 2 female doctors was the taking of temperature of patients who complained of fever.

D. Knowledge, Attitude and Practice of Pharmacists (Form 4)

	Knowledge			Attitude			Practice		
	HQ	IQ	LQ	HQ	IQ	LQ	HQ	IQ	LQ
Nangarhar	3	1		2	2		4		
Ghazni	1	3	1	3	1			4	

Note:Nangarhar, total = 4
Ghazni, total = 5 but attitude and practice of pharmacist of Khwaja Umari because of late arrival of team

This cadre of health workers has had no formal training. Most of the pharmacists are also not qualified personnel but school teachers etc who have been trained on the job. The majority of them are women. This means that the male Main Office Pharmacists have difficulty training them formally within Afghanistan. The questionnaires were made in conjunction with the Main Office pharmacist who felt that on the job training had been done regarding the issues included for evaluation. ***However, there is one trained female pharmacist in Bagrami clinic with 16 years of work experience. It is possible that she can be used for training of female pharmacists.***

Knowledge:
- knowledge of dosages for commonly used drugs.

Attitude:
- Most pharmacists did not inform patients of some common side effects.

Practice:
- Some did not have formularies on the table. Some had not been given one and some had it at home.

E. Knowledge, Attitude and Practice of Health Educators (Form 5)

All Health Educators achieved high quality scores for all three aspects.

Knowledge:
However, many of them did not know the quantity of ORS to be given for the prevention of diarrhoea as this is not taught to them. These are present in the 'Case Definitions' but not in the HE manual. Some verticalisation of systems seems to be leading to this.

In Ghazni, the Health Educator in Gardez did not fare so well. However, she is a new recruit. The topic was malaria but the teaching aids for the routes of transmission of disease were used. This was not picked up by the person evaluating her. This shows that supervisory staff are not conversant with some technical issues they are required to supervise. Her attitude and practice were good according to the criteria used.

Other Observed Problems:
There are some minor problems like:
- The pictures on the causal chains are too small
- In 2 clinics the ORT table was inside the clinic and not accessible to waiting patients so the ORT corner was more or less rendered pointless
- 1 health educator had the ORT corner outside but uncovered. Also, a cover made of netting is not sufficient to protect the ORS from the dust flying around where the ORT corner is outside the building.

The biggest problem in Health Education is the lack of adequate space for this activity. Part of the problem is that IbnSina as a policy asks the community to contribute a building if one is not available from the MOPH. This necessarily means that the building

is not designed for clinic use. There is an additional problem, in that there is no such thing as a community building in the true sense. A building is contributed by a private person who expects employment for a member of his family or asks IbnSina to move once the building is in a decent condition to one that needs rehabilitation.

Various recommendations were made to the Regional team for improvement of the current spaces for health education. Charbag and Shiveh need the constructions of more 'sayabons'. Muqour needs some major rehabilitation.

Muqour has an additional problem. The Taliban authorities refuse to let female receptionist deal with male patients or men bringing their children. 2 separate spaces will be needed for health education for both men and women.

The HE is also responsible in most cases for growth monitoring. In Shiveh, the HE did the education outside and then had to run into the clinic occasionally to do the growth monitoring.

One important point is that during the health education sessions, the children are, more or less, disregarded or regarded as a nuisance as they make a noise and run around etc. There are often enough older children to make it worth while to target the children in addition to the mothers. Perhaps one session could be held especially for the children. This would need different methods and teaching aids.

The Health Education Supervisor has difficulties training this all female cadre by virtue of being male. He has not been included in any training for Growth Monitoring but the staff he supervisors are responsible for this activity. However, he has been in position only since last year.

F. Knowledge, Attitude and Practice of Receptionists (Form 6)

All receptionists in Nangarhar obtained high quality scores for all three aspects.

In Ghazni, the receptionist in the Ghazni Markaz clinic was not able to guide the patients to the correct rooms nor to prioritize very sick patients. This is as much fault in the organization as in the person. The space for the reception room is shared by the Health Educator and is very small. If the waiting space were to be enclosed, the HE could use that space and this would leave the receptionist less cramped.

The receptionist in Muquor had resigned and the CHS was discharging this responsibility and also doing the weighing of children. He has obviously not been trained for wither activity properly.

The family cards in Gardez had finished. Patient cards and family cards finish quickly.

The Gardez MCH clinic has three waiting areas. There are insufficient benches for the patients. It is very difficult to have a streamlined patient flow in the current situation without some rehabilitation.

G. Knowledge, Attitude and Practice of Nurses (Form 7)

All 4 nurses in Nangarhar, achieved a high quality score in knowledge. 1 had an intermediate score in attitude and 2 had an intermediate score in practice.

Of 5 nurses in Ghazni, 2 got an intermediate score in knowledge and 1 obtained an intermediate score in practice.

The Main problems were in ***Practice:***
The nurse in Shiveh was new and had not participated in the training course. The nurse in Bagrami got flustered by the evaluation and forgot to make up the antiseptic solution for the thermometers and tongue depressors and therefore got a lower score in practice.

The nurse who scored poorly in practice, was not familiar with the use of chlorine for high level disinfection and had not made up the solution for use in the female examination room, injection area and EPI area. The Ghazni Markaz clinic has no injection/dressings room as these are done in the adjacent Maternity Home.

All of the workers in this cadre are not professionally qualified. Many have an educational qualification and have been trained on the job. A formal course for initial training has been held earlier in 2001 for nurses in Nangarhar only. The TBA Trainer/Supervisor is a qualified nurse trainer and the support of nurses is now included in her job description. She is based in Nangarhar.

An observation was made by the person evaluating nurses in Ghazni that while many of them achieved a good score according to the forms, in practice, many of them had problems eliciting vital signs. The form only assesses knowledge of normal ranges for vital signs.

H. Knowledge, Attitude and Practice of Growth Monitoring (Form 8)

Training for female health educators who are responsible for this activity has been held in Nangarhar. Male doctors, who will use the GM charts in the treatment of the children, were trained in all the regions. The male doctors in Ghazni, Kandahar and Bamyan were requested to train the respective person in their clinics after the training.
A formal training for growth monitoring in Ghazni is scheduled to be held after the evaluation. The Female PHC Supervisor has recently participated in a nutrition workshop held by WHO and she will conduct the traininig.

The scale in Qarabag clinic, Ghazni, was broken and the Regional Office had no spare scale to replace it in stock. In Muqour, the CHS was weighing the children and those who

ACKNOWLEDGMENTS

Acknowledgments are due to the staff of the Nangarhar and Ghazni regional offices for their enthusiastic participation the evaluation process and their hospitality. Thanks are also due to the staff of the Technical Section at the Main Office who have contributed to the design of the evaluation format.

I would like to thank Dr.Gyuri Fritsche who has generously shared his evaluation of the Swedish Committee's Programme with me and the technical papers which he had used to research the evaluation design.

As this is my final task with IbnSina, I would like to take this opportunity to thank the whole organization for their friendship, support and all that we have learned together. I would like to record my admiration for their continuing endeavors under difficult circumstances. The staff in the field have many difficulties to contend with and yet they continue they work. The improvements that have taken place over the years are a testimony to the work of all the staff as a team.

I would like to conclude by wishing IbnSina continuing success in their undertakings and the Afghan people, peace and a secure future.

Panna Erasmus
27.06.01

were accompanied by their mothers were sent to the Health Educator. The waiting area for these patients was disorganized; mothers going off for vaccination, some going to see the female doctor etc.

Quality Rating of Growth Monitoring

	Knowledge			Attitude			Practice		
	HQ	IQ	LQ	HQ	IQ	LQ	HQ	IQ	LQ
Nangarhar	3		1	2	2		2	2	
Ghazni	2	2	1	1				1	

Note: the attitude and practice in Khwaja Umari was note seen because the team was late. The attitude and practice in Qarabag was not seen as the scale was broken. In Muqour, attitude and practice was not seen as the responsibility was divided between the CHS and the Health Educator in a most confused manner

Knowledge:

Knowledge regarding growth faltering and failure needed prompting. The knowledge of responsibles in Ghazni was of course poorer than in Nangarhar because of a lack of formal training. However, the male doctor in Khwaja Umari had done a commendable job of training the Health Educator in his clinic.

Attitude:

Some of the staff did not tell the mother of the outcome of the weighing and what it meant.

Practice:

In Charbag and Shiveh, the mother had not been advised to store her card in a plastic bag. Bags for these cards are not supplied to the clinics, though some clinics had them; the region having procured them locally. Some did not check that the scale was zeroed before weighing. Some did not enter the weight on the card and join the line.

In Ghazni, all the staff use the Roman calendar months for the age of the child. The Afghan months should be used as this will lead to less error. In Ghazni Markaz, the children are being measured for height as well because they are under the impression that this is a criterion required by MSF for entry into their therapeutic feeding program. This creates a lot more work for an already over burdened worker who has difficulty coping currently. The matter will be negotiated with MSF.

The HE in Shiveh had difficulty in reading the scale.

The main problem again in this area of activity, apart from a lack of training, is the organization of the patients and the place in which it is conducted. Many missed opportunities arise since there is no proper place. Adequate spaces for health education and growth monitoring need to be created.

I. Laboratory Quality

No form was designed for assessing the quality of the laboratories. During the evaluation, a comment was made by the female doctor in Charbag that many patients whom she had

clinically diagnosed as being anaemic , returned with levels of 14 to 16 Grams% etc. Acting upon this comment, laboratory registers were examined for haemoglobin test results. In Charbag, Shiveh and Khwaja Umari the registers do not show many or any anaemic patients for the past month. This is not possible, as anaemia is a common problem of multiple origins in Afghanistan. The Laboratory Supervisor states that method haemoglobin is a fairly reliable one provided the technique is correct.

Haemoglobin results seem to be a fairly good rule of thumb indicator that the laboratory quality is not as it should be, especially by those supervisors who do not have the technical expertise to check other tests. About 20 to 30% of all haemoglobin tests should show a degree of anaemia. In fact preliminary results of a clinic based survey of haemoglobin levels in women shows that about 65% of all women are anaemic.

J. Exit Polls of Patients (Form 9)

3 patients were interviewed for each section by 3 different interviewers. The person who attended the health education session, interviewed patients for recall of health education messages.

	HQ	IQ	LQ	Remarks
Medical Consultations				
Nangarhar	1	2		Side effects of medicines not known by patients. Charbag poll not done
Ghazni	1	4		Time of next appointment not known. Side effects of medicines not known.
Vaccination				
Nangarhar				Total number of doses/visits to complete course not known. Time of next appointment not known.
Ghazni		2	2	Total number of doses/visits to complete course not known. Time of next appointment not known. Side effects of vaccination and what to do for fever not known.
Health Education				
Nangarhar	4			Information well retained.
Ghazni	4			Information well retained.

The doctors felt that since all patients did not need to return, the question assessing their attitude was 'unfair'. However, if the patient does not need to return he/she should be so informed.

Training of vaccinators should include an emphasis on telling mothers of the number of total doses/visits that they must complete. It would reduce some of the drop out.

K. Quality of the Maternity Homes/Emergency Obstetric Centers (Form 10)

Like the clinic quality score, the EOCs were assessed for:

- structural quality, including power source, laundry, neonatal resuscitation table, emergency drugs cupboard and duty room for night staff
- continuous presence of staff
- essential drugs and medical supplies
- essential equipment

The EOC in Gardez scored a high quality. The EOC, Ghazni, scored an intermediate quality because 2 drugs and 1 item of medical supply were not present. The 2 drugs were infusions and the supply was autoclave indicator tape. The Regional Office did have these supplies but these had not been requisitioned. Again a system of a minimum stocks would lessen this kind of problem.

An analysis of cases was done and related to the use of infusions:

Cases in Ghazni Maternity home April 2001 and Infusions Used

Cases Needing Infusions	**Total Infusions Used**
Incomplete abortions = 27	Ringer Lactate = 59
Missed abortions = 12	Sodium Chloride = 30
Retention Placenta = 11	Dextrose 5% = 59
Complicated Deliveries = 37	Saline and Dextrose = 0
Caesarian Sections = 13	
Total cases = 100	**Total Infusions used = 148**

Some of the cases may need more than 1 bag of fluid. The use of infusions seems fairly reasonable.

Partograms are used in both facilities though their use and subsequent action was not assessed. The knowledge, attitude and practice of the staff of the EOCs were not evaluated. Different forms need to be designed for this.

Study visits by the Regional staff especially the female PHC supervisor to Baraki Barak and Mehterlam hospitals would be a useful learning experience.

The rehabilitation undertaken in the Ghazni EOC has improved the facility considerably. A little more work on the laundry area needs to be undertaken to avoid accumulation of pools of water. A mesh door needs to put on the pit latrine for patients. The delivery room needs a ceiling cloth.

Some suggestions were put forward by the staff:

- A 2 week visit by the senior midwife from the Ghazni EOC to organize and improve the Gardez services
- One type of cord clamp does not grip the cord and opens up. These should not be supplied . Those supplied by Morton plastics are effective.
- Ketamine should be supplied. There is an anaesthetist at the hospital who is willing to provide the necessary training.
- Hydralazine ampoules and Magnesium sulphate infusions if available should be supplied in small quantities for the treatment of eclamptic patients
- They would appreciate a creche for their many babies

Output of the EOCs

<u>Average number of deliveries per month:</u>	
Ghazni EOC (including Caesarian Sections)	110
Gardez EOC (No C. Sections)	65
<u>Other cases including abortions and retained placenta:</u>	
Ghazni EOC	50
Gardez EOC	25

The Ghazni EOC has been in operation for about two and a half years. The Gardez EOC has been open only for the last eight months.

OTHER OBSERVATIONS

The forms used for the evaluation were of course not comprehensive. Many issues came up through observation of what was essentially an integrated manner of evaluation. These were:

- Exit polls of patients led to the observation of a patient who had been prescribed several drugs from a private pharmacy by both the male and female doctors of Muqour clinic. These were expensive drugs. Paracetamol, that the clinic had not run out of, was also prescribed from the pharmacy. It turned out that the Lab. Technician owns a pharmacy in partnership with another person. While no conclusions can be made firmly, the Regional office will investigate this further.
- Exit polls also showed that some patients did not have their children weighed. Some whose children had been weighed, did not have the weight marked on the chart and did not understand the outcome of the weighing. Some of the patients had not been vaccinated.
- The patients in the Maternity Home in Gardez have great difficulty getting on and off the examination tables. All facilities should have wooden steps to help the patients get on and off.
- Organization of patient flow is very important both to deliver effective health education and help patients seek care easily but also to decrease missed opportunities for all aspects of health care.

- The furniture in most clinics is quite old and shabby, often shaky and dangerous.
- Many of the pharmacies hand out drugs through a space that has been created by rolling up the wire mesh. It would be perfectly possible to have the net attached to a wooden rod so that the space is neat and not hazardous.
- A visit to waiting patients the Gardez MCH clinic showed that many had not weighed. As they were brought to the HE to weigh, about 5 malnourished babies were seen. One mother was feeding her baby commercial biscuits dissolved in water in a bottle. The baby was severely marasmic and there seemed to be little chance of it surviving. If this is a constant feature in Gardez, another NGO with the capacity to run a Therapeutic feeding Center should be explored.
- Another waiting patient had been prescribed the combined oral contraceptive 40 days after delivery and her milk supply had decreased. She had been put on the pill by a private practitioner in Kabul. The training of the private sector should be considered where possible.
- An analysis of work loads for different workers was done:

Nangarhar, April 2001

	Patients per day; 2 doctors	Laboratory tests per day	Dental visits per day	Fixed center vaccinations per day
Charbag	62	23	4	13
Bagrami	69	19	NA	18
Shiveh	46	16	NA	NA
Qasaba	63	23	NA	12

Note: NA = not applicable
2 vaccinators per fixed center

Ghazni, April 2001

	Patients per day; 2 doctors	Laboratory tests per day	Dental visits per day	Injections per vaccinator per day
Ghazni Markaz	64	32	NA	21
Khwaja Umari	38	8	1.2	21.3
Gardez	45	23	NA	29
Qarabag	44	14	NA	21.6
Kakrak	-	-	2	-
Muqour	67	32	NA	32.6

Note: NA = not applicable
Only dental visit analysis done for Kakrak

From the above tables, it can be seen that the number of dental visits is extremely small in both regions. Dental visits include extractions, scaling and treatment of dental or gingival infections. Anecdotal evidence suggests that these services are valued in the

communities. If their services are to be retained, it would make sense to include other responsibilities in the duties of the dental technicians to fully utilize their time.

The output of vaccinators per day in Ghazni is better than in Nangarhar.

There were very few laboratory tests in Khwaja Umari. The technician has had several absences and his haemoglobin tests also seen dubious. This will be investigated by the region.

III. OBJECTIVE 3

The capacity of the Regional staff to support and supervise the clinics is dependent on several factors:

- Appropriate technical skills and knowledge
- Sufficient resources i.e. drugs and supplies, transport, money on time, manpower
- Motivation
- Good communications systems between the MO, the RO and the clinics
- Clearly understood policies and decision making and lines of authorities

While all of these were not formally assessed, some discussions were held with staff. The following points were noted:

1. Some of the technical systems are somewhat vertical. EPI, Laboratory and health education sections have different supervisors. The Directors and the PHC supervisors are not aware of all the technical contents of these issues. In turn, the Health Education Supervisor is not aware of the Growth Monitoring guidelines. The Main Office is responsible for the development of technical guidelines and training planning. It should try and integrated training for the supervisory category of staff. In some aspects it may be more difficult than in others e.g. laboratory supervision. A beginning has already been made in EPI. The PHC supervisors participated in an EPI orientation course. The Regional Directors have not. Since this training, there has been some turnover in supervisory staff and there are some gaps now.
2. There is a request for training in management skills for the Directors. Management is one of their core responsibilities.
3. The MO has been very regular in its support of the regions with finance, transport and drugs and supplies. The drugs issue has been discussed else where. There is a suggestion that an extra stock in Afghanistan would ease problems. There have been some bottlenecks. The generator in Ghazni has not been working for the past 4 months. Since the evaluation, the necessary spare parts have been supplied. The lack of a generator has meant that the staff have to work in the evenings when the commercial power supply from a private generator is available. There are suggestions from both Nangarhar and Ghazni that locally manufactured generators are cheaper, easier to repair and will reduce their dependency on the MO for spare parts. The Maternity Home in Gardez has no generator. The MO needs to consider budgeting for adequate power sources in future budgets.

4. IbnSina has invested in radios in the 4 regions since the Mid Term Evaluation. Since then, it is not possible to communicate from Pakistan by radio as it is forbidden by the GOP. This leads to some communications difficulties. Bamyan and Ghazni use the services of the Kabul office for logistical support and communications forwarding. There is no radio in Kabul. There is no regular pouch system from Kabul by which the Bamyan, Ghazni and Kabul mail would be regularly forwarded. There is a facility called the urgent mail service that guarantees mail delivery to Peshawar in 24 hours. If a fixed day a week is set for pouch dispatch, Bamyan and Ghazni would be able to organize their mail to be delivered accordingly. Nangarhar is not a problem but a regular system would be valuable. The UN accepts pouches in Kandahar. All these possibilities should be investigated. There is talk of a radio telephone system that works from Karkhano. This could be used by the MO for direct communications with the field.
5. There are 2 other systems of communications: satellite telephones and capsat sets. Both need to be purchased in Europe and hand carried into Pakistan and installed by an experienced person. Both possibilities should be investigated for pros and cons and attempts made to install one.
6. Kabul and Nangarhar both say that there is talk that digital phone systems will be installed in these 2 locations by the Chinese.
7. Apart from the difficulties caused by communications difficulties there are complaints from the Regions that repeated requests have to be made to elicit any answers or action.
8. The Ghazni office suggests that the supervision budget for that region is not in line with the number of supervisory staff that it manages.
9. Regular meetings with clinic heads at the RO should aid communications with the RO and the clinics.
10. The Regional office have their own small training budgets that are meant to be used for training of their staff in English, computer use and other locally available courses. It seems that they do not have the authority to use these budgets and need permission from the MO. This often takes a long time. This issue needs to be examined and lines made clear.
11. The Health Education and Laboratory supervisors have requested training for updating their skills. Their own training has taken place some time ago and this request should be given serious consideration.
12. The training of nurses, pharmacists and health educators presents problems for those regions that do not have the technical capacity. The possibilities of using the pharmacist in Bagrami as a trainer and the use of the TBA trainer/supervisor in regions other than Nangarhar should be considered. IbnSina has plans to hold 2 courses in Peshawar in Reproductive Health for nurses. General nursing training will be added on to these courses and will help.
13. The training of the midwives in the EOCs is another issue to be considered separately as their responsibilities are different to those of the nurses in the clinics. Masooda in Ghazni is said to be an experienced and senior midwife. She has no experience in training. Perhaps she could be developed to carry out training responsibilities.
14. Staff motivation is a complex issue. IbnSina pays fairly good wages. It provides regular training, supervision and support. There has been a recent recognition that

there is no reward for experience and commitment and achievements. There is a determination to examine this issue and evolve a system that will provide a grading ladder. This will certainly help motivation. There are other issues that might help:

- Where it is necessary for staff to be resident in the office, attention should be paid to their accommodation and recreational facilities.
- Staff within the country have a problem that staff in Peshawar do not have: educational facilities for their children. This is important not only for staff motivation but also the future of the country. Discussions should be held with those organizations including the UN that provide educational support to investigate the possibilities.
- Creches for the small children of female staff. Most of the clinics are MCH clinics and have a large number of female staff. Some of them do not have the support of an extended family.

CONCLUSIONS AND RECOMMENDATIONS

Objective 1: To assess how far the recommendations of the previous evaluation have been implemented and how this has affected the organisation.

1. A substantive portion of the recommendations made during the Mid Term Evaluation have been implemented. Many of those that have not been implemented, are not in the control of IbnSina e.g. signing of contracts by UNICEF, consultancy by Memisa.
2. The changes that have been made have contributed to improvements in IbnSina's program and efficiency. The recruitment of deputies for key positions means that IbnSina is less vulnerable to the inevitable turn over of staff that takes place.
3. A suitable person needs to be identified and recruited to mange the Community Based Health Program to take it forward.
4. IbnSina has not expanded its program since the evaluation significantly. This has given it the time to consolidate its efforts.
5. Significant improvements have been made in EPI coverage and capacity building.

Objective 2: To assess the quality of care at clinic level

1. The evaluation of the clinics using the forms to examine each component of care at the clinic by the team of Regional staff has been a constructive learning experience.
2. The Regional teams have found that this exercise has helped them to get a fresh perspective of the needs in the clinics. It has also helped them to get a holistic picture of the clinics' work.
3. The evaluation of the clinics included issues that had been part of recent training e.g. use of chlorine solution for high level disinfection, growth monitoring, Reproductive Health, redistribution of drugs within and between regions to avoid expiry etc. **It is a positive development to see that the training is actually being implemented in the field.** It speaks well of the filed staff and the supervision and monitoring provided by the Regional Offices and the Main office.

4. The Regional staff felt that this kind of exercise undertaken periodically, with modification of the forms would be a useful addition to the range of supervisory techniques used. Some of the Regional Directors suggested that the staff of one region should evaluate another region, in order to minimize bias.
5. All 9 clinics rated as intermediate quality on the structural quality score. The predicted quality had been high for all but 1 clinic. The sole reason for this rating was the lack of one or drugs or medical supplies. The criteria for a high score was the presence of all the drugs and supplies. The assessment done by the SCA and the study on which it was based, rates a clinic as having a high score on the supplies if 50% of the drugs are present. Had that criterion been used, the clinics would all have achieved a high rating.
6. The Maternity Home in Ghazni rated an intermediate quality because of a lack of some supplies. The Maternity Home in Gardez achieved a high score.
7. The lack of drugs and supplies in many clinics suggests that a system of minimum stock levels should be instituted.
8. A database for drugs and supplies needs to be designed so that the Main Office and the Regional Offices can help clinics maintain adequate stocks.
9. Paediatric dosages should be supplied in the extra kits. Paediatric dosage tablets should be included in the drugs supplies.
10. The possibilities of introducing some flexibility of purchasing some drugs in Afghanistan if needed.
11. A 3 month stock pile should be maintained in the country at any time so that supply of extra drugs should be possible.
12. The amounts of drugs supplied needs to be re-examined. Should the dual system of prescribing drugs from the bazaar when the monthly quota finishes continue? This can lead to difficulties in the monitoring and supervision of rational drug use.
13. No expired drugs were seen in the clinics visited. Significant improvements have been achieved by the organization to this end.
14. It should have been possible for IbnSina to purchase syringes for the EPI program in Ghazni form its own budget for drugs etc. Communications and swift responses are perhaps the sore issue.
15. The assessment of the knowledge, attitude and practice of the health workers high-lighted training needs. The gaps are disucussed in detail in the results section. Some of these are:
    - Some common obstetric and gynaecology subjects should be included in the training of male doctors.
    - Case definitions and treatment guidelines for common obstetric and gynaecological problems need to be drawn up.
    - Patients should be informed of their diagnosis, how to take their drugs and when to return.
    - Formal training for pharmacists, possibly using the trained pharmacist in Bagrami, should be though of.
    - Formal training for nurses and midwives needs to be undertaken.
    - The fact that several cadres were not fully aware of some of the details of the use of ORS shows that some simple treatment issues should be taught to all staff members, including cleaners and watchmen. The risk signs in pregnancy should

also be taught to all staff and the range of contraceptives available at the clinic and the simpler indications and contra indications.
- EPI cadres and all clinic staff should be able to tell mothers how many doses/visits are needed to complete a vaccination schedule.

16. Some of the technical systems are vertical. A common issue is treated differently by, for example, the health educators and the people conducting growth monitoring. The supervisory staff are not familiar with the teaching aids used in health education. New systems should be introduced after the supervisory staff have had some training in it.
17. No form was designed for the evaluation of laboratory quality. The percentages of haemoglobins that are below the normal seems like a good dipstick indicator of the quality. 30 to 60 % of haemoglobins should indicate anaemia.
18. Health education for older children in the clinics should be considered and appropriate materials and training procured.
19. The health education and reception activities suffer form some confusion. Adequate space is often not available. The use of private houses as clinics means that a building is being used that is not designed to help patient flow. IbnSina should consider the construction of clinics by it or a construction NGO in its future plans. This confusion in patient flow and organization is leading to missed opportunities in EPI. Growth monitoring and health education.
20. Currently, patient waiting spaces can be improved by the construction of shades etc.
21. The clinic furniture needs to be standardized and be of a medium quality. Steps for all examination tables should be part of each examination room checklist. More detailed suggestions for improvement of the physical structure of the clinics are made in the results section.
22. Patient exit polls will reveal a lot of valuable information. These should be undertaken regularly by all supervisory staff. The exit polls in Muqour showed a possible irregularity in prescription practice. The staff may be involved in prescribing medicines and supplies from a pharmacy owned by the lab. Technician. This will be investigated by the Region.
23. This brings out the conflict of interest that may arise between clinic duties and private practice. The fact that the staff work part time and have private practices in the afternoons will aggravate this conflict of interest. IbnSina should discuss ways and means in which this can be supervised adequately. One suggestion is that staff should not be allowed to own or participate in any private pharmacies.

Objective 3: To assess the capacity at Regional level to maintain and improve quality of care in the facilities

The capacity of the Regional staff to support and supervise the clinics is dependent on several factors:

- Appropriate technical skills and knowledge
- Sufficient resources i.e. drugs and supplies, transport, money on time, manpower
- Motivation
- Good communications systems between the MO, the RO and the clinics

EXECUTIVE SUMMARY

IbnSina is a relatively new Afghan Non Governmental Organization created by AVICEN as that part of it which would be the provider of Primary Health Care. This move was made in response to the coordinated European support (MEMISA/European Union/NOVIB) program which took up the responsibility of providing PHC in four regions of Afghanistan. In November 1996, IbnSina became independent of AVICEN. Since then, it has continued in the pursuit of it's twin goals of good quality PHC provision and the formation of a high caliber, accountable Afghan NGO, working in the service of Afghanistan. It has been jointly financed by the EU, MEMISA and NOVIB. The EPI component has been financed by UNICEF. UNFPA has funded the strengthening of the Reproductive Health Care since 2000.

A Mid-Term Evaluation of IbnSina's program was undertaken in November 1998 by a team consisting of 2 staff from Memisa and 2 external consultants. One of the external consultants was the Technical Advisor for the Swedish Committee for Afghanistan. The other consultant joined IbnSina as a Technical Advisor after the evaluation. About two and a half years have elapsed since the evaluation.

IbnSina felt that it would be a valuable exercise to conduct an internal evaluation; looking more closely at the service delivery level than at the program and organizational levels. Therefore it was decided that the evaluation would have three main objectives:

1. To assess how far the recommendations of the previous evaluation have been implemented and how this has affected the organization.
2. To assess the quality of care at clinic level
3. To assess the capacity at Regional level to maintain and improve quality of care in the facilities.

Objective 1

All project documents were reviewed to assess the follow up on recommendations of the Mid-Term Evaluation. 37 of the 47 recommendations have been implemented. The result has been a real strengthening of organizational capacity and an improvement in the quality of its service delivery. The recruitment of deputies for key positions makes IbnSina less vulnerable to the loss of staff and ensures continuity.

The capacity building and training of various cadres of staff has been undertaken with visible application of learned skills in the field. The output of the EPI program has improved significantly. About 80% of children under one are fully immunized in the Ghazni region and 60% in Paktika. The coverage in Nangarhar is also more than 80%. The coverage for fully immunized under ones in Bamyan has risen from 7% to about 45%. The coverage in Kandahar has risen from 15% to 50%. The coverage for TT has also risen significantly to about 3 times the previous level. However, it is still low.

Communications between the regions has improved after the installation of radios in 4 offices. However, the Pakistan Government has banned the use of radios in Pakistan by

- Clearly understood policies and decision making and lines of authorities

While all of these were not formally assessed, some discussions were held with staff. The following points were noted:

1. Some of the technical systems are somewhat vertical. EPI, Laboratory and health education sections have different supervisors. The Directors and the PHC supervisors are not aware of all the technical contents of these issues. In turn, the Health Education Supervisor is not aware of the Growth Monitoring guidelines. The Main Office is responsible for the development of technical guidelines and training planning. It should try and integrated training for the supervisory category of staff. In some aspects it may be more difficult than in others e.g. laboratory supervision. A beginning has already been made in EPI. The PHC supervisors participated in an EPI orientation course. The Regional Directors have not. Since this training, there has been some turnover in supervisory staff and there are some gaps now.
2. There is a request for training in management skills for the Directors. Management is one of their core responsibilities.
3. The MO has been very regular in its support of the regions with finance, transport and drugs and supplies. The drugs issue has been discussed else where. There is a suggestion that an extra stock in Afghanistan would ease problems. There have been some bottlenecks. The generator in Ghazni has not been working for the past 4 months. Since the evaluation, the necessary spare parts have been supplied. The lack of a generator has meant that the staff have to work in the evenings when the commercial power supply from a private generator is available. There are suggestions from both Nangarhar and Ghazni that locally manufactured generators are cheaper, easier to repair and will reduce their dependency on the MO for spare parts. The Maternity Home in Gardez has no generator. The MO needs to consider budgeting for adequate power sources in future budgets. Generators for the Nangarhar, Ghazni and Bamyan offices and one each fro the EOCs should be considered.
4. IbnSina has invested in radios in the 4 regions since the Mid Term Evaluation. Since then, it is not possible to communicate from Pakistan by radio as it is forbidden by the GOP. This leads to some communications difficulties. Bamyan and Ghazni use the services of the Kabul office for logistical support and communications forwarding. There is no radio in Kabul. There is no regular pouch system from Kabul by which the Bamyan, Ghazni and Kabul mail would be regularly forwarded. There is a facility called the urgent mail service that guarantees mail delivery to Peshawar in 24 hours. If a fixed day a week is set for pouch dispatch, Bamyan and Ghazni would be able to organize their mail to be delivered accordingly. Nangarhar is not a problem but a regular system would be valuable. The UN accepts pouches in Kandahar. All these possibilities should be investigated. There is talk of a radio telephone system that works from Karkhano. This could be used by the MO for direct communications with the field.
5. There are 2 other systems of communications: satellite telephones and capsat sets. Both need to be purchased in Europe and hand carried into Pakistan and installed by an experienced person. Both possibilities should be investigated for pros and cons and attempts made to install one.

6. Kabul and Nangarhar both say that there is talk that digital phone systems will be installed in these 2 locations by the Chinese.
7. Apart from the difficulties caused by communications difficulties there are complaints from the Regions that repeated requests have to be made to elicit any answers or action.
8. The Ghazni office suggests that the supervision budget for that region is not in line with the number of supervisory staff that it manages.
9. Regular meetings with clinic heads at the RO should aid communications with the RO and the clinics.
10. With the new reporting systems, it will be possible to calculate the number of new patients. It will then be possible to provide a sufficient number of patient cards to the regions..
11. The Regional office have their own small training budgets that are meant to be used for training of their staff in English, computer use and other locally available courses. It seems that they do not have the authority to use these budgets and need permission from the MO. This often takes a long time. This issue needs to be examined and lines made clear.
12. The Health Education and Laboratory supervisors have requested training for updating their skills. Their own training has taken place some time ago and this request should be given serious consideration.
13. The training of nurses, pharmacists and health educators presents problems for those regions that do not have the technical capacity. The possibilities of using the pharmacist in Bagrami as a trainer and the use of the TBA trainer/supervisor in regions other than Nangarhar should be considered. IbnSina has plans to hold 2 courses in Peshawar in Reproductive Health for nurses. General nursing training will be added on to these courses and will help.
14. The training of the midwives in the EOCs is another issue to be considered separately as their responsibilities are different to those of the nurses in the clinics. Masooda in Ghazni is said to be an experienced and senior midwife. She has no experience in training. Perhaps she could be developed to carry out training responsibilities.
15. Study visits to other relevant institutions like EOCs run by other organization etc. would be a valuable developmental tool for the Main Office and Regional Office staff.
16. Dental technicians are under-employed. Additional responsibilities should be included in their job descriptions.
17. Staff motivation is a complex issue. IbnSina pays fairly good wages. It provides regular training, supervision and support. There has been a recent recognition that there is no reward for experience and commitment and achievements. There is a determination to examine this issue and evolve a system that will provide a grading ladder. This will certainly help motivation. There are other issues that might help:
    - Where it is necessary for staff to be resident in the office, attention should be paid to their accommodation and recreational facilities.
    - Staff within the country have a problem that staff in Peshawar do not have; educational facilities for their children. This is important not only for staff motivation but also the future of the country. Discussions should be held with

those organizations including the UN that provide educational support to investigate the possibilities.

- Creches for the small children of female staff. Most of the clinics are MCH clinics and have a large number of female staff. Some of them do not have the support of an extended family.

NGOs. The problem of communication between the Main Office and the Regional offices remains. Various alternatives have been suggested in the section titled 'Conclusions and Recommendations'.

Intensive training in Reproductive Health has taken place in 2000 of all doctors and Mid Level Health workers. In addition, about 60 community level male workers have had an orientation course in Reproductive Health.

IbnSina has not expanded its program in terms of geography or numbers of facilities significantly. This has allowed the organization to consolidate its work and engage in significant capacity building of staff.

Of the 10 recommendations not implemented, 7 are not within the sole control of IbnSina. They depend on outside agencies like UNICEF and the donors. An experienced manager for the Community Based Health Program has not been identified, a referral system for TB patients has not been formalized where possible and the board has not been able to play an active role in fund raising.

Objective 2

Evaluation forms were designed for clinic quality and EOC quality. Forms were also designed to assess the knowledge, attitude and practice of all skilled staff working in the clinics, except the laboratory technicians.

9 clinics and the 2 Maternity Homes or Emergency Obstetric Centers (EOCs) were visited in 2 of the 4 regions in which IbnSina operates its Primary Health Care Program. All the clinics and the EOC in Ghazni were ranked as having an intermediate quality. The EOC in Gardez achieved a score for high quality. The sole reason for their not achieving a high quality score was the lack of one or more drugs or medical supplies. One of the papers on which the form design was based, stipulates the presence of only 50% of drugs supplied, at the time of evaluation. The criterion used in this evaluation was the presence of all essential drugs in the quantities stipulated. This is a much more stringent standard and has been used because regular and adequate supply has been a feature in which IbnSina prides itself. Perhaps this standard is a little too stringent.

The lack of drugs has raised a number of issues related to drug supply, which are discussed in detail in 'Conclusion and Recommendations'. The policy needs to be re-examined as regards quantities, paediatric drugs, minimum stock levels, a 3 month store in country and the possibility of in country purchasing. A few additional drugs such as ketamine, hydralzine etc need to be considered for the EOCs. A separate drugs register needs to be designed for the EOCs.

The evaluation of the knowledge, attitude and practice of various cadres has identified training needs. There has been an improvement in many areas where training has been given. Posts such as pharmacists and nurses are largely filled by women who have had

secondary education but are not professionally trained. Formal training courses for these workers should be considered.

The evaluation teams have found the exercise useful and valuable. The evaluation of a clinic by a team looking into all aspects of the clinic, was seen as different type of supervisory and learning technique. The staff involved in the evaluation have suggested the regular use of this exercise, with modification of the tools. They have also suggested that a region could be evaluated by a team from another region. The staff of 2 regions now have had training in the use of these tools and experience in their use. They can serve as a nucleus of skills in this regard.

IbnSina's policy of using buildings donated by the 'community' has made the program less expensive, in that money is not spent on clinic construction. However, this policy makes it vulnerable to the private family who actually donates the building for use. They expect employment for their family or will ask the clinic to shift after rehabilitation has made the building suitable for habitation. The fact that the building has not been designed for clinic use makes it very difficult to organize patient flow, health education and growth monitoring.

IbnSina should explore alternatives: linking up with an NGO that will budget for and construct clinics or budgeting for clinic construction and sub-contracting the work to a construction NGO.

Partnership with other NGOs that deal with issues such as therapeutic feeding or treatment of tuberculosis need to be explored and formalized. Clinic staff need to have a clear understanding of the referral systems.

Objective 3

The Regional Offices have the task of supporting the clinics materially and technically. The capacity of the staff in the region needs to be a mix of management and technical skills. The Regional Offices visited supervise and supply the clinics on a regular basis according to a work plan. Like all routine work, the supervision can become too 'routinised' and the outputs will lack a creative vision. The Main Office can encourage a fresh perspective by holding supervisory visits at the same time as the Regions are holding their regular meetings with clinic heads. Data analysis, discussions of problems and policies and decision making on the spot that are recorded and understood could be a very valuable process.

Technical and Management Skills

Some of the technical systems are somewhat vertical. EPI, Laboratory and health education sections have different supervisors. The Directors and the PHC supervisors are not aware of all the technical contents of these issues. In turn, the Health Education Supervisor is not aware of the Growth Monitoring guidelines. The Main Office is responsible for the development of technical guidelines and training planning. It should

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- The quality of care at the clinic level
- The follow up of the recommendations made during the external Mid Term Evaluation
- The capacity at Regional level to maintain and improve quality of care in the facilities

Political Context

The situation in Afghanistan has remained relatively unchanged since the evaluation in 1998. The Taliban control about 90 to 95% of the country. Takhar has recently fallen to them. However, there is still active fighting in the region. Recently fighting has re-started in the Hazarajat area and during this reporting period, front lines have opened up in Yakawlang.

The Taliban are as yet not granted UN recognition and in fact, new sanctions have been imposed upon them, with some tacit support for the Northern Alliance from many international players. Taliban decisions such as the destruction of the Bamyan Buddhas, new edicts to close home schools for girls, the requirement for all non- Muslim Afghans to wear yellow distinctive badges etc. do not enhance their image abroad.

The complex humanitarian crisis in Afghanistan continues and is exacerbated by the third year of drought. This, together with the fighting, has led to internal displacement and further out migration. The Pakistan government has imposed tighter controls on the formerly free movement across the borders and have refused to grant land use to the